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In The

Supreme Court of the United States

SUN LIFE ASSURANCE COMPANY OF CANADA,

Petitioner,

v.

MARGARET T. WHITE,

Respondent.

On Petition For Writ Of Certiorari To The United States Court Of Appeals For The Fourth Circuit

REPLY TO BRIEF IN OPPOSITION

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REPLY TO BRIEF IN OPPOSITION

Respondent's arguments completely ignore the practical aspects of the problem presented in this case. From the perspective of benefit plan sponsors, administrators, fiduciaries, and insurers, the practical problem is this: it defies logic to tell entities who operate benefit plans that plan terms cannot be enforced when the language at issue is uniformly mandated for inclusion in plan documents by governmental authorities, when the language at issue is clear and unambiguous, and when the language as applied is reasonable and provides plan participants and beneficiaries with more than adequate opportunity to assert their rights under the plan and applicable law. Put more simply – if benefit plans are required by uniform state insurance laws to include specific terms in their plan documents, they ought to be able to enforce those terms as written.

I. THERE IS A SPLIT IN THE CIRCUITS THAT MUST BE RESOLVED.

To confirm that there is a split in the circuits, this Court needs to go no further than the Third Circuit's own admission in *Miller v. Fortis Benefits Ins. Co.*, 475 F.3d 516 (3d Cir. 2007), in which that court rejected a proof of claim accrual provision and instead adopted the "clear repudiation" rule as the "federal default accrual rule," stating "we realize that our application of the clear repudiation rule *diverges from that of other courts* confronting the *same issue*."

Id. at 523 (emphasis added). Further proof of the circuit split is in the dissent below where Chief Judge Wilkins emphasized that the majority's position was contrary to decisions in other circuits that had enforced proof of claim accrual provisions. *White v. Sun Life Assurance Co. of Canada,* 488 F.3d 240, 262-63 (2007). Both the Third Circuit and Chief Judge Wilkins recognized that circuit law regarding the enforcement of proof of claim accrual clauses and even regarding an appropriate "federal default accrual rule" is hopelessly fractured.

Respondent's position that there cannot be a circuit split until every court of appeals has engaged in a detailed discussion of an issue is based on at least two unfounded assumptions. First, Respondent assumes that circuit courts are blind to the issues. Certainly circuit courts are capable of addressing issues, particularly if they are concerned that plan terms are not consistent with ERISA. Five circuits have no such concerns about proof of claim accrual provisions. Second, Respondent assumes that if the five circuits that have enforced proof of claim accrual clauses do engage in a more detailed analysis, they will agree with Respondent. Respondent provides no basis for such an assumption. Indeed, the discussion and holding in *Doe v. Blue Cross & Blue Shield United of Wisconsin*, 112 F.3d 869 (7th Cir. 1997) prove just the opposite. Respondent also ignores the practical problem that before 2007, benefit plans could rely on decisions in five circuits to enforce insurance policy accrual provisions, with only the Ninth Circuit

dissenting, whereas in 2007, two other circuits have joined the Ninth Circuit in rejecting insurance policy accrual provisions, turning what was barely a split into a yawning void. To make matters worse, and as the Third Circuit acknowledged in *Miller*, the three circuits that currently refuse to enforce insurance policy accrual clauses have each adopted a different version of what the court below called a "federal default accrual rule," with each version of the "default rule" requiring a different case-by-case factual analysis.

Respondent's position that the issue has not "percolated" is incredible. Proof of claim accrual clauses have been mandated by insurance regulators for over fifty years. This Court referred to such a clause as a "standard contractual provision" as long ago as the decision in *Order of United Commercial Travelers of America v. Wolfe*, 331 U.S. 586, 612 n. 23 (1947). Over the last fourteen years, eight circuit courts have had occasion to consider such clauses in determining whether an ERISA plan participant or beneficiary filed a timely lawsuit. Granted, this includes two unpublished decisions, but even before this Court's recent amendment of the Federal Rules of Appellate Procedure to give precedential value to unpublished circuit court decisions, some circuits (including the Sixth and Tenth Circuits) routinely considered unpublished decisions, particularly when evaluating issues on which there were no published

decisions in the applicable jurisdiction.[1] Finally, district court decisions on the enforceability of proof of claim accrual clauses are not as uniform as Respondent represents, with a substantial number of district court cases enforcing such clauses.[2] Clearly,

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[1] *See* 6th Cir. Rule 28(g) (2005) and 10th Cir. Rule 36.3(B) (2003), permitting citation to unpublished decisions where pertinent to the issues.

[2] Respondent's contention that only one district court has taken the opposite position is simply untrue. A number of district courts from the Fifth, Seventh, Eighth, Tenth, and Eleventh Circuits have enforced reasonable and unambiguous contractual limitations periods in ERISA cases, including proof of claim or similar accrual clauses. *See, e.g., Alexander v. Prudential Fin., Inc.*, 2006 U.S. Dist. LEXIS 73741 (S.D. Tex. 2006) (rejecting the plaintiff's argument that the contractual limitations period should not apply because accrual of the cause of action under ERISA can only occur by way of denial of benefits and upholding a valid and reasonable contractual limitations period, explaining that the Fifth Circuit has upheld contractual limitations periods stemming from the time in which proof of loss is required); *Ind. Reg'l Council of Carpenters Pension Trust Fund v. Fid. & Deposit Co. of Md.*, 2007 U.S. Dist. LEXIS 15429 (N.D. Ind. 2007) (applying state law in a diversity case, but relying on *Doe v. Blue Cross & Blue Shield United of Wisconsin*, 112 F.3d 869, 873 (7th Cir. 1997) to note that if this were a suit under ERISA, a different outcome would obtain because the Seventh Circuit has concluded that contractual limitations, if reasonable, are enforceable in suits under ERISA); *Hall v. Employee Benefits Manager Analytical Techs., Inc.*, 2001 U.S. Dist. LEXIS 22240 (S.D. Ind. 2001) (holding that the major premise that an ERISA cause of action does not accrue, and the limitations period does not begin, until there has been a final denial is untrue, explaining that, when a cause of action is ripe for litigation is a separate and distinct issue from when the limitation period begins and explaining further that, in the Seventh Circuit, contractual limitation periods are permissible

(Continued on following page)

this issue has "percolated," not just at the circuit court level, but also at the district court level. Respondent's implication that there may be a sea change that might bring uniformity to circuit law in the future is baseless.

II. THE MAJORITY DECISION BELOW IS WRONG.

Respondent's argument that Petitioner is trying to elevate state law over federal law ignores the very substantial federal principles at work in this case. One of the foundational principles of ERISA is that benefit plans must be in writing and that plan terms must be enforced as written. A corollary to this principle is that Congress left most plan terms to the discretion of plan drafters, especially in the case of welfare plans, including life, health, and disability plans. This was undoubtedly due in large part to the fact that many such benefit plans are insured and insurance policy terms are already highly regulated

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and will be enforced under *Doe v. Blue Cross & Blue Shield United of Wisconsin*, 112 F.3d 869, 874 (7th Cir. 1997) if they are reasonable, even if they began prior to the final denial); *Gonser v. Cont'l Cas. Co.*, 2007 U.S. Dist. LEXIS 72357 (E.D. Ark. 2007) (enforcing a three-year contractual limitations period from the time proof of loss is required); *Melton v. Unum Life Ins. Co. of Am.*, 2006 U.S. Dist. LEXIS 71815 (W.D. Okla. 2006) (enforcing policy provision excluding any action commenced more than three years after proof of claim is required as reasonable); *Smith v. Cont'l Cas. Co.*, 2007 U.S. Dist. LEXIS 51125 (N.D. Ga. 2007) (holding that contractual limitations periods in ERISA actions are enforceable, provided they are reasonable).

by state law. *See, e.g.*, 29 U.S.C. §1002(1) (defining an employee welfare benefit plan as a plan, fund, or program that provides specified benefits "through the purchase of insurance or otherwise. . . .") In fact, Congress expressly exempted state insurance laws from the otherwise broad scope of ERISA preemption. 29 U.S.C. §1144(b)(2)(A). The deference that Congress chose to extend to state insurance laws and to written plan terms generally makes enforcement of the accrual provision in this case a matter of federal law, not state law.

Respondent's contention that this Court has "made clear" that federal courts should apply a default federal accrual rule to a federal cause of action is simply a misrepresentation of the holdings cited by Respondent. None of the cases cited by Respondent dealt with private contractual agreements – let alone insurance policies with language mandated by state insurance laws – that expressly provided for when a limitations period would begin. *See Rotella v. Wood*, 528 U.S. 549 (2000); *Bay Area Laundry & Dry Cleaning Pension Trust Fund v. Ferbar Corp.*, 522 U.S. 192 (1997); *Reiter v. Cooper*, 507 U.S. 258 (1993); *Rawlings v. Ray*, 312 U.S. 96 (1941). Although a federal accrual rule would generally apply when a federal statute is silent on the issue, where, as here, private parties stipulate that the limitations period begins when proof of claim is due under the policy, and where, as here, there is no dispute that this provision provided the claimant with a reasonable period in which to file suit, it would be inappropriate

to allow federal common law to circumvent the unambiguous language of the plan. *See Order of United Commercial Travelers v. Wolfe*, 331 U.S. at 608 (requiring federal courts to determine if a period is reasonable whenever a contract alters an otherwise applicable limitations period).

III. THIS CASE PROVIDES THE IDEAL VEHICLE FOR RESOLVING THE CIRCUIT SPLIT.

The facts of this case permit this Court to address directly the legal issue at hand. Respondent concedes that the benefit plan language is clear and unambiguous. Respondent concedes that, as applied to this case, the accrual clause in the plan permitted Respondent more than adequate time to file suit arising from her denied benefit claim. Furthermore, the plan provision at issue is uniform nationally, so a decision by this Court will apply uniformly across the country.

Respondent argues that her suit was timely because the plan at issue omitted another clause supposedly mandated by North Carolina law that, according to Respondent, would allow her to file suit arising from Sun Life's decision to deny her initial claim for benefits until all future potential benefit periods expire under the plan when Respondent reaches age 65. Aside from the fact that this supposed "limitations period" would be no limitation at all, Respondent's implicit assumption that the Sun Life policy form was authorized for issuance by the North

Carolina Department of Insurance even though it omitted a necessary clause, is not only ludicrous, but is without any support in the record. Suffice it to say that Respondent attempted this same argument in both the district court and the court of appeals and no judge has endorsed her argument. To the contrary, the only two judges to comment – the Magistrate Judge in the district court and Chief Judge Wilkins in the Fourth Circuit – both soundly rejected Respondent's argument. App. 71-72; 488 F.3d at 258 n. 2.

Respondent's contention that Petitioner did not argue that insurance policy accrual provisions are mandated by state law until it filed a petition for rehearing is not only wrong, but irrelevant. It is wrong because Petitioner argued as early as the district court that the Policy accrual provision was mandated by state insurance law. Petitioner renewed this argument on appeal. Indeed, in his dissent, Chief Judge Wilkins specifically noted that North Carolina "and the vast majority of other states" require the proof of claim accrual provision. 488 F.3d at 259. Thus, the matter was raised early on in this case and long before Petitioner filed its request for rehearing.

Respondent's argument is also irrelevant because the point would not have initiated any need for "discovery" as Respondent suggests. What possible discovery would be needed to determine whether 49 states require a proof of claim accrual rule? Indeed, Respondent has had many months since Petitioner sought rehearing in the Fourth Circuit and she does

not even challenge the fact that such a requirement exists.[3]

In the end, the suggestion that a so-called federal default accrual rule promotes uniformity better than an unambiguous accrual clause in an employee benefit plan is simply not true. Uniformity is best promoted by insurance laws in 49 states that require insurance policies to include the same accrual language, which laws are themselves the products of uniform model laws developed by the National Association of Insurance Commissioners. Uniformity is best promoted by insurance policy provisions that have been in place using essentially the same language for at least fifty years. Finally, uniformity is best promoted by unambiguous language in ERISA plan documents that are required by law to be distributed to ERISA plan participants, rather than by case law pronouncements regarding "default rules" of which most participants and beneficiaries would not be aware and that themselves vary from jurisdiction to jurisdiction.

Given the national scope of ERISA regulation of employee benefit plans, plan sponsors, administrators, fiduciaries, and insurers have a right to expect uniform regulation. Where ERISA does not provide a

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[3] The fact that the Fourth Circuit denied rehearing arises more from the contention that there was no dispute *within* the Fourth Circuit than the fact that there is a dispute *between* the Fourth Circuit and other circuits. The Fourth Circuit obviously recognized that the latter dispute is for this Court to resolve.

limitations period, leaving the matter to the discretion of plan drafters, and where courts otherwise adopt state statutory limitations periods to fill the "gap" in the ERISA statute, and where state insurance laws mandate uniform language to be included in insurance policies that more often than not fund benefits under life, health, and disability plans, the uniform language ought to be enforced uniformly. Plan sponsors, administrators, fiduciaries, and insurers certainly should be able to rely on and enforce plan terms as written.

CONCLUSION

For the reasons stated herein and in Petitioner's principal brief, Petitioner respectfully requests that the Court grant review and reverse the ruling below.

Respectfully submitted,

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